DEPARTMENT OF CHILDREN AND FAMILY SERVICES

ACTION TRANSMITTAL 2022.01

DATE: February 15, 2022

TO: All DCFS and Purchase of Service Agency Permanency and Intact Family Services Workers and Supervisors, Licensing Representatives and Supervisors; DCFS Residential Monitoring Staff; ILO/TLP Program Administrators and Staff; and Congregate Care Facility Administrators and Staff.

FROM: Marc D. Smith, Director

EFFECTIVE: **Immediately**

I. PURPOSE

The purpose of this Action Transmittal is to provide an updated guidance regarding the health and safety measures and in-person contacts amid the COVID-19 public health crisis based on current recommendations from the Centers for Disease Control (CDC) and Illinois Department of Public Health (IDPH). This Action Transmittal **replaces** Action Transmittal 2021.05.

II. PRIMARY USERS

Primary users include all DCFS and Purchase of Service Agency Direct Service Staff, including Permanency Workers, Intact Family Services Workers, Residential Monitors, Licensing Representatives and their respective Supervisors; and Residential/Congregate Care Facilities licensed by DCFS, including Group Homes, Shelters, Child Care Institutions/Residential Treatment Facilities.

III. BACKGROUND AND SUMMARY

Beginning very early in 2020, through the present date, the Department has been continually assessing the status of the COVID-19 public health crisis in Illinois and its impact on the safety of in-person contacts. Special considerations have been and continue to be taken to prevent disease transmission of COVID-19 when youth or residents, visitors and staff move into and within programs, foster homes and congregate care settings.

IV. DEFINITIONS

"Exposure" means contact with someone infected with SARS-CoV-2, the virus that causes COVID-19, in a way that increases the likelihood of getting infected with the virus.[1]

"Close contacts" means someone who was less than 6 feet away from an infected person (laboratory confirmed or a clinical diagnosis) for a cumulative total of 15 minutes or more over a 24-hour period, for example, three individual 5-minute exposures for a total of 15 minutes. An infected person can spread COVID-19 starting 2 days before the person has any symptoms, or for asymptomatic people 2 days before the positive specimen collection date.[2]

"Isolation" is a strategy used to separate people with confirmed or suspected COVID-19 from those without COVID-19.[3]

"Quarantine" is a strategy used to prevent transmission of COVID-19 by keeping people who have been in close contact with someone with COVID-19 apart from others. [4]

V. INSTRUCTIONS – Health and Safety Measures

The Department continues to monitor, and update guidance based on current recommendations from the Centers for Disease Control (CDC) and Illinois Department of Public Health (IDPH) to meet the needs of children and families served as well as continuing to meet emergency and critical needs as they arise. The instructions that follow provide enhanced guidance under the current conditions of COVID-19 cases across the state:

a) Personal Protective Equipment (PPE)

The health and safety of the children and families served as well as our partners and workforce are of the utmost importance. Personal Protective Equipment (PPE) continues to be made available, to all DCFS staff, and can be ordered for all DCFS offices. Purchase of Service agencies may be assisted by DCFS in securing PPE supplies as needed.

Permanency Workers are encouraged to continue to carry additional PPE at all times to ensure that every adult and child, over 2 years of age and developmentally able, wears a mask for the duration of in-person contacts. Staff should follow IDPH guidelines, regarding masking.

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[1] Quarantine and Isolation Definitions Updated January 20, 2022 https://www.cdc.gov/coronavirus/2019-ncov/yourhealth/quarantine-isolation.html#quarantine

[2] Appendix A Glossary of Key Terms Updated January 4, 2022 https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.html#Key-Terms.

[3] CDC Guidance on Quarantine and Isolation Updated January 20, 2022. https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html

[4] CDC Guidance on Quarantine and Isolation Updated January 20, 2022. https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html

Congregate settings should continue to update their agency visitation policies to reflect IDPH guidance. These written guidelines should include the agency's response regarding any person(s) refusal to wear a mask. This guidance should include a short, easy-to-read fact sheet on visitation policy for residents and visitors. The agency should distribute the visitation policy to residents and post the visitation policy on the facility's website.

b) Quarantine[5]

Calculating quarantine: The date of your exposure is considered day 0. Day 1 is the first full day after your last contact with a person who has had COVID-19.

1) ***If you were exposed and are NOT up-to-date on COVID-19 vaccinations, CDC recommends that:***

A) For at least 5 full days: stay at home and quarantine; wear a well-fitted mask if you must be around others in your home; and get tested at least 5 days after you last had close contact with someone with COVID-19 even if you do not develop symptoms.

i) If unable to quarantine, wear a well-fitting mask for 10 days when around others at home and in public.

ii) If unable to wear a mask when around others, continue to quarantine for 10 days. Avoid household members and others who are immunocompromised or at high risk for severe disease and other high-risk settings until after at least 10 days.

iii) Do not travel during the 5-day quarantine period. Before traveling, get tested and make sure the test result is negative if asymptomatic. If unable to test, delay travel until 10 days after the last close contact. If travel must occur before the 10 days are completed, wear a well-fitting mask when around others for the entire duration of travel during the 10 days. If unable to wear a mask, do not travel during the 10 days.

B) Until 10 days after you last had close contact with someone with COVID-19:

a. Wear a well-fitted mask for 10 full days any time you are around others inside your home or in public; do not go to places where you are unable to wear a mask; avoid travel; and avoid being around people who are at high risk.

[5] CDC Guidance on Quarantine and Isolation Updated January 20, 2022. https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation/html#quarantine

b. Watch for symptoms, including fever (100.4◦F or greater), cough, shortness of breath, or other COVID-19 symptoms.

c. If you develop symptoms isolate immediately and get tested. Continue to stay home until you know the results and wear a well-fitted mask around others. If you test positive, follow isolation recommendations.

d. If you do not develop symptoms:

i) If you test negative, you can leave your home, but continue to wear a well-fitting mask when around others at home and in public until 10 days after your last close contact with someone with COVID-19.

ii) If you test positive, you should isolate for at least 5 days from the date of your positive test (if you do not have symptoms). If you do develop COVID-19 symptoms, isolate for at least 5 days from the date your symptoms began (the date the symptoms started is day 0). Follow recommendations in the isolation section below.

iii) If you are unable to get a test 5 days after last close contact with someone with COVID-19, you can leave your home after day 5 if you have been without COVID-19 symptoms throughout the 5-day period. Wear a well-fitting mask for 10 days after your date of last close contact when around others at home and in public.

iv) Avoid people who are immunocompromised or at high risk for severe disease, and nursing homes and other high-risk settings, until after at least 10 days.

2) ***If you were exposed to COVID-19 and are up-to-date on COVID-19 vaccinations, CDC recommends that:***

A) You do not need to stay home unless you develop symptoms.

B) Even if you do not develop symptoms, get tested at least 5 days after you last had close contact with someone with COVID-19.

C) Take precautions until day 10: wear a well-fitted mask for 10 full days any time you are around others inside your home or in public. Do not go to places where you are unable to wear a mask. Avoid travel. Avoid being around people who are at high risk.

D) Watch for symptoms until 10 days after you last had close contact with someone with COVID-19, including fever (100.4◦F or greater), cough, shortness of breath, or other COVID-19 symptoms.

E) If you develop symptoms isolate immediately and get tested. Continue to stay home until you know the results and wear a well-fitted mask around others. If you test positive, follow isolation recommendations.

3) ***If you were exposed to COVID-19 and had confirmed COVID-19 within the past 90 days (you tested positive using a viral test), CDC recommends that:***

A) You do not need to stay home unless you develop symptoms.

B) Take precautions until day 10: wear a well-fitted mask for 10 full days any time you are around others inside your home or in public. Do not go to places where you are unable to wear a mask. Avoid travel. Avoid being around people who are at high risk.

C) Watch for symptoms until 10 days after you last had close contact with someone with COVID-19, including fever (100.4◦F or greater), cough, shortness of breath, or other COVID-19 symptoms.

D) If you develop symptoms isolate immediately and get tested. Continue to stay home until you know the results and wear a well-fitted mask around others. If you test positive, follow isolation recommendations.

4) ***Quarantine in high-risk congregate settings.***

In certain congregate settings that have high risk of secondary transmission, the CDC recommends a 10-day quarantine for residents, regardless of vaccination and booster status. During periods of critical staffing shortages, facilities may consider shortening the quarantine period for staff to ensure continuity of operations. Decisions to shorten quarantine in these settings should be made in consultation with state and local health departments and should take into consideration the context and characteristics of the facility. CDC's setting-specific guidance provides additional recommendations for these settings.[6]

[6] CDC Guidance on Quarantine and Isolation Updated January 20, 2022. https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html

c) Isolation.[7]

Calculating isolation: Day 0 is your first day of symptoms or a positive viral test. Day 1 is the first full day after your symptoms developed or your test specimen was collected. If you have COVID-19 or have symptoms, isolate for at least 5 days.

If you tested positive for COVID-19 or have symptoms, regardless of vaccination status:

1) Stay home for at least 5 days and isolate from others in your home.

   A) If possible, stay in a separate room and use a separate bathroom.

   B) Do not share personal household items, like cups, towels, and utensils.

   C) Do not travel.

2) Wear a well-fitted mask if you must be around others in your home.

3) Ending isolation

   A) If you had symptoms: end isolation after 5 full days if you are fever-free for 24 hours (without the use of fever-reducing medication) and your symptoms are improving. If you continue to have fever or your other symptoms have not improved after 5 days of isolation, you should wait to end your isolation until you are fever-free for 24 hours without the use of fever-reducing medication and your other symptoms have improved.

   B) If you did not have symptoms: end isolation after at least 5 full days after your positive test.

   C) If you were severely ill with COVID-19: you should isolate for at least 10 days. Consult your doctor before ending isolation.

4) Take precautions until day 10:

   A) Wear a well-fitted mask for 10 full days any time you are around others inside your home or in public. Do not go places where you are unable to wear a mask.

   B) Avoid travel.

   C) Avoid being around people who are at high risk.

[7] CDC Guidance on Quarantine and Isolation Updated January 20, 2022. https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html#quarantine

Isolation in high-risk congregate settings[8]

In certain high-risk congregate settings that have high risk of secondary transmission and where it is not feasible to cohort people (such as correctional and detention facilities, homeless shelters, and cruise ships), CDC recommends a 10-day isolation period for residents. During periods of critical staffing shortages, facilities may consider shortening the isolation period for staff to ensure continuity of operations. Decisions to shorten isolation in these settings should be made in consultation with state, local, tribal, or territorial health departments and should take into consideration the context and characteristics of the facility. CDC's setting-specific guidance provides additional recommendations for these settings.

d) **IDPH and DCFS advise the following measures be taken:**

The Illinois Department of Public Health (IDPH) and DCFS strongly advise and recommend that all providers eliminate pre-admission testing requirements. Requiring pre-admission testing prevents the fluidity of movement of youth into residential and congregate care settings. A negative result for COVID-19 on pre-admission testing creates a false sense of security. This has resulted in failure to follow appropriate quarantine recommendations, multiple preventable COVID-19 exposures, and has caused significant delays in transition of youth to less restrictive environments.

The residential/congregate care placement should communicate directly with youth for screening questions; it is best not to rely on second hand information.

1) Delay transfer if COVID symptoms are present.

2) Regional, unit and agency staff should prescreen for COVID-19 symptoms and possible exposure before in-person contacts.

   - Interview youth and caregiver for COVID-19 symptoms.
   - Delay in-person contact if symptoms are present.

3) Mask and practice infection control when transporting children and youth.

   - Youth and caseworker must wear a mask during the entire trip.
   - Masks must be worn appropriately covering both mouth and nose.

[8] CDC Guidance on Quarantine and Isolation Updated January 20, 2022. https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html#quarantine

4) Follow guidelines of IDPH with adherence to isolation or quarantine when advised.

- Initiate appropriate COVID testing protocol, if asymptomatic testing is deemed necessary, after arrival to facility. If the test is positive, proceed with isolation per CDC protocol. For the initial precautions, providers should ensure:
    - That youth is social distancing; and practicing good infection control
    - When it is necessary to be in the presence of others the youth should wear a mask.
- If prior to admission, during the interview process, a child or youth is exhibiting physical signs or symptoms of COVID-19 or has been in close contact, within **6 feet of an infected person** (laboratory-confirmed or a clinical diagnosis) for a cumulative total of 15 minutes or more over a 24-hour period, the child or youth shall be quarantined for 10 days. Quarantine is not required after exposure to COVID-19 for: 1) individuals with up-to-date on COVID-19 vaccinations; or 2) individuals who have tested positive for COVID-19 in the previous 3 months.
- Isolation separates sick people with a contagious disease from people who are not sick.
    - Caregivers entering the room of an isolating person should continue to wear mask, gown and gloves.[9]
    - These items should be removed at the door when exiting the room.
- Quarantine separates and restricts the movement of people who were exposed to COVID-19 to determine whether they develop symptoms or test positive for the disease.
    - Residents, known to be in close contact with a confirmed case, are restricted to their unit and monitored for symptoms.
    - Staff should be designated to the effected unit and not float between units.[10]
    - Only staff assigned to care for minors on the specific unit should be allowed to enter the unit.

[9] Infection Control for Nursing Homes & Long-Term Care Facilities Updated September 10, 2021. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

[10] Infection Control for Nursing Homes & Long-Term Care Facilities Updated September 10, 2021. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

- All therapy interactions should be virtual while a unit is under quarantine as therapists frequently go to various units and or facilities.

- Off unit school, routine healthcare, and any form of visitation must be rescheduled or completed virtually.

- Every effort should be made to vaccinate youth 5 years or older and all staff against COVID-19.

VI. INSTRUCTIONS FOR SERVICE DELIVERY

a) In-person contact and visits.

Child Protective Services investigative contacts shall continue to occur as required in Procedures 300.

For all levels of substitute care, intact family services, ILO/TLP and residential/congregate care, a minimum of one in-person contact must occur every 30 days. Direct service staff must ask all COVID-19 prescreening questions when scheduling and upon arrival at any in-person visits. For specialized foster care cases, in-person worker–child contacts shall occur a minimum of twice per month, along with one additional video conference contact, for a total of 3 worker-child contacts per month.

1) Parent - Child Visitation

In-person parent-child visitation shall occur weekly, as required by DCFS rules and procedures, when reunification is the permanency goal.

For medically complex and fragile children/youth, a medical professional shall be consulted to assess the well-being of the youth, and the arrangements before in-person weekly parent-child visit resume.

The location of parent-child visitation shall be determined by the agency or region, (home, DCFS offices, family environments, Purchase of Service Agency offices, or other community-based resources).

Unsupervised in-person visitation shall continue. Any considerations for modifications based on safety and well-being should be addressed in a formal Child and Family Team and documented with a Critical Decision case note. Administrative and legal consultation should be considered when warranted.

2) Sibling Visits

Sibling visits shall occur in-person, twice per month, as required by DCFS rules and procedures.

3) **Required Caseworker Contacts**

With Youth in Substitute Care. Permanency Workers shall continue to conduct at least one in-person visit with each child in substitute care every 30 days. Visitation should be increased when warranted.

With Pregnant and Parenting Youth. All visitation with pregnant and parenting youth in care shall occur as required by DCFS rules and procedures. A medical professional shall be consulted as needed.

With Parents. For families with children residing in the home, worker – parent visitation shall occur in-person at least every 30 days and as required by DCFS rules and procedures. Permanency Workers shall ensure that children who reside in the home are seen in-person and separately during these visits. Visitation can be increased when warranted.

When there are no children residing in home of parent, monthly worker-parent visits shall continue to be in-person.

With Unlicensed Relatives. Unlicensed HMR/Fictive Kin foster care shall have two in-person visits per month as required by DCFS rules and procedures.

With Youth in Specialized Foster Care. On an interim basis; at minimum, Specialized Foster Care client contact shall be: two in-person worker-child contacts monthly when there are no safety issues present. A required third monthly contact can be completed using video conferencing. All contacts must be documented in SACWIS. If there are safety concerns, there is an expectation that all three-monthly contacts occur in-person .

Licensing Staff Visits (Foster Family Homes and Congregate Care). In-person visits shall be conducted as required in the applicable DCFS licensing rules.

With Youth in Congregate Care Facilities.

A) Residential monitors will conduct at least one unannounced on -site observation monthly to the congregate care facility as safety and risk factors allow.

B) Permanency staff will conduct monthly in-person visitation and contact the Residential/Congregate Care facilities by phone or email prior to visitation to inquire regarding their ability to host in-person visits. If the facility cannot allow in-person visitation due to COVID-19 mitigation measures, permanency staff will document this information in a case note and shift their visitation to virtual until the medical concern has been mitigated.

C) While concurrently adhering to the IDPH Long-Term Care Facilities Guidelines and DCFS requirements; in-person family visitation will be at the discretion of the residential/congregate provider and done in collaboration with DCFS Residential monitoring while considering individualized health and safety factors such as:

- IDPH and CDC guidelines during the duration of in-person contact;
- Underlying health conditions of the youth and family or residents within the facility;
- Other youth in the residential/congregate care setting who have tested positive with COVID-19 or who have been exposed to someone who tested positive with COVID-19.

D) Permanency Workers are encouraged to supplement in-person contacts with video conferencing as it has been demonstrated that, during peak pandemic periods, these youth benefited from the increased contact with their Permanency Workers.

4) **Reunification Services**

As it relates to Reunification/After Care; in-person contact and services shall continue as required by DCFS rules and procedures.

5) **Child Welfare Services Referrals (CWS)**

CWS referrals/intake evaluations shall be assigned to a caseworker within 24 hours. The assigned caseworker shall conduct an in-person visit with the children and family within 48 hours, but no later than 5 working days, of assignment, to assess the safety of the children and service need.

6) **Intact Family Services**

All in-person contacts and services shall occur as required by DCFS rules and procedures or as required by court order.

In-person contact shall occur during joint initiation of new investigations, in coordination with the Child Protection Specialist/Supervisor.

7) **Child Protection Services**

All investigations, case handoffs, court referrals and services shall occur as required by DCFS rules and procedures.

b) Video Conferencing Use Guidance.

1) Video conferencing can be used as an alternative to in-person ACR, CIPP, Countdown to 21 or clinical staffing's when its clinically appropriate and applicable. When used; there must be strict adherence to HIPAA guidelines and attention to the privacy of our youth and parents. **Additionally, in all instances, youth must have an assigned caseworker or support (caregiver, treatment provider, therapist, etc.) present with them during a video meeting.**

2) **Video conferencing cannot be utilized in the place of required in-person contact.**

3) Video conferencing can be used to allow additional contacts with a youth in a congregate care setting, foster/relative home placement or with a parent or caregiver. **Video conferencing does not replace, and cannot be used as a substitute for, a required in-person contact.**

4) Child and Family Team Meetings are recommended to be in-person, when applicable. Consideration should be given for the preference of the family's team members when deciding whether to conduct the CFTM in-person or virtually. The caseworker shall document this decision in a case note.

c) On-Site Visitation Plans for Youth in Congregate Care Settings

Any revisions to On-Site Visitation Plans must be submitted to the agency's Residential Monitor for review and approval. This plan should be shared with internal and external DCFS stakeholders (i.e., caseworker/supervisors, DCFS licensing, GAL/CASA) and should be adjusted as Public Health guidance continues to evolve.

Agency On-Site Visitation Plans are required to include the following components:

1) Specific protocols and requirements for visitors, youth and staff
   - Universal masking
   - Environmental cleaning procedures
   - Hand hygiene and availability of hand sanitizer
   - Staff training requirements and social distancing expectations

2) Scheduling of visits and screening procedures
   - Youth, families and DCFS/POS staff should be notified that visitation is offered, the hours of visitation and how to schedule visitation during conversations with family or during a CFTM.
   - Youth and visitors should be informed of safety expectations during visits (i.e., use of PPE, social distancing) as part of the scheduling process and provided with educational materials as needed.

- Screening procedures for visitors and youth should be detailed and may include screening at the time of scheduling as well as immediately prior to the visit.
- At the time of the visit, check-in procedures should include required infection control procedures (i.e., hand washing and sanitation) be completed. Creation of screening/sanitation stations and identification of single points of entry are recommended.

3) The location of visitation spaces
   - Outside spaces for visitation that include comfortable accommodations (appropriate seating, shaded areas, etc.) and allow for social distancing are minimally required.
   - Agencies should consider providing "clean" spaces designated inside the facility for visitation that can be easily accessed by visitors and disinfected after each use. Agencies should post signage for what the "clean" space should be used for (i.e., doffing PPE, disposing of items used during the visit, etc.).
   - Signage to promote safe visitation should be posted.

4) Length and frequency of visits

5) The number of visitors and ages of visitors permitted at any one time

6) Supervision of visits
   - The plan should indicate staff who will be available to supervise, when applicable. When visits do not need to be directly supervised, the plan should indicate staff who will provide oversight and be available to aid youth and visitors.
   - The plan should indicate how private visits with legal caseworkers/supervisors and monitors will be completed.

7) Written protocols regarding food/meals during visits, if applicable
   - If food/meals are allowed, your plan should address the use of disposable utensils, which should be disposed of in the "clean" space afterwards.
   - Clearly identifying any prohibitions to food/meals such as not sharing small bites or bringing birthday cake and candles.
   - Stressing the use of universal masking while serving food and maintaining social distancing.

8) Planning for activities during visits
   - Clearly articulate what can and cannot be brought to the visit.

9) Conditions under which visits will be cancelled or postponed if someone displays or reports symptoms.
   - Indicate if visits will be conducted or limited if the program is experiencing a COVID-19 outbreak.

10) Procedures for sanitizing visitation spaces after each use

11) Expectations for follow-up reporting by visitors of COVID-19 symptoms or infection
    - Visitors should report COVID-19 symptoms that developed after the visit (including timeframe) to the agency.
    - The agency should follow its standard operating procedures to determine exposure and consult with nursing or the Medical Director, and the local Public Health Department.

d) Off-Site Visitation Guidance for Youth in Congregate Care Settings

Off-site visits continue to be allowed for youth who are able to have supervised, unsupervised, and overnight visitation as well as for those who require transitional visits to facilitate moving from residential and group home programs to home-based discharge living arrangements (i.e., home of parent, foster care, TLP) and congregate care discharge living arrangements (i.e., TLP, CILA, group home, residential program). Visitation guidelines may be adjusted in accordance to mitigation efforts in response to community-based and or specific facility transmission rates. ACFTM should be convened prior to any visitation to ensure expectations and rules are clear.

For any type of off-site visitation individualized planning with the youth's child and family team should occur prior to the visitation. Prior to any off-site visitation, youth and all visitation participants should be screened for symptoms and exposure one day before a scheduled face-to-face visit and on the day of the visit. If anyone reports symptoms or close contact during screening, the visit should be postponed. Screening questions include:

- Within the last 14 days, have you or anyone in your home (or congregate care program) experienced symptoms: loss of sense of taste or smell, headache, sore throat, body aches, coughing, shortness of breath, nausea/vomiting, diarrhea or a fever of 100.4˚ F or higher?
- Within the last 14 days, have you or anyone in your home (or congregate care program) been in close contact (closer than 6 feet for at least 15 minutes without use of a face covering) with someone confirmed to have COVID-19?

Frequent check-in meetings during visits (especially extended visitation) are required to regularly assess the health status of the youth and all visitation participants (e.g., household members, staff/youth in the congregate care program), compliance with safety rules, overall stability, challenges, etc.

In the event the youth or visitation participants report COVID-19 symptoms or exposure to a close contact during an extended visit, the youth's planning team should immediately be notified and a staffing should be completed to determine next steps (e.g., isolation or quarantine at the current location or the residential/group home, complete testing, implementation of additional safety rules). The planning team should debrief following visitation to determine if the visitation plan should be revised or updated.

Overnight Visitation

Overnight and extended visits to a home-based living arrangement will be permitted if household members being visited have agreed, in advance, to abide by the CDC safety measures as recommended by IDPH to reduce exposure to COVID-19. Visits may be put on hold only if there are concerns about possible COVID-19 exposure for the youth or their visiting resource. Additionally, household members shall acknowledge that they do not have known exposure to COVID-19 or symptoms of COVID-19 or have received a negative test result since their last known exposure.

Unsupervised visits will be limited to the home or future residence of the youth. The youth and family must practice the following safety measures:

1) The residential program staff will review COVID-19 safety guidelines with the visiting resource while the youth is at home.

2) Visiting resources should immediately report to the agency any COVID-19 symptoms that developed after the visit.

3) While on the visit, the youth and family should follow all applicable IDPH and CDC guidelines while participating in community activities or visiting indoor public places.

4) If a positive case is confirmed at the residential program or during the visit staff will hold a staffing within 24 hours to determine best approach to ensure safety and follow the guidance of the agency's medical director and/or nursing staff, IDPH and DCFS Chief Nurse.

5) If a youth tests positive, the youth's CFT shall convene a meeting to determine if the youth will quarantine at the visiting resource's home so as not to hinder the transition process. If the visiting resource is not in support of that option, all visits shall cease and the CFT shall re-evaluate the timeline for visitation or transition.

6) Return Expectations from Off-Campus Visits:
   - The youth will be expected to change clothes, wash hands, and get temperature checked before returning to their unit.
   - Youth will need to be under close observation and the agency must implement infection control measures such as social distancing, wearing a mask, stringent hand hygiene and environmental cleaning in addition to monitoring for symptoms.

Transitional Visitation

The youth's CFT, including representatives of the residential/group home program, are responsible for completing transition planning to adequately prepare the youth and caregiver for discharge and promoting safe visitation. If a CFT for the youth/family has not been established, the residential services team (including the youth, DCFS/POS caseworker/ supervisor, GAL/CASA, and other individuals

supportive of the youth) should complete transition planning in collaboration with the caregiver (or congregate care provider staff). If the youth's case will be transferred upon discharge from the residential and group home program, the receiving caseworker and supervisor should also participate in planning.

1) The following issues should be addressed by the youth's team when completing planning for transitional visitation:
   - The number of visits and duration by type of visit
   - Risks to safe visitation and mitigation strategies
   - Agreed-upon safety rules
   - Transportation to, from and during visits when applicable.
   - Safety supplies (i.e., face coverings, hand sanitizer, disinfecting cleaning products) required by the youth and individuals in the home-based environment.
   - Check-in requirements during extended visitation (including who will check in, how frequently, and issues to discuss).
   - Additional supports provided during extended visitation by different team members.

2) The type, frequency and duration of visitation should be tailored to meet the needs of the youth and caregiver (or congregate care provider) while minimizing the risk of COVID-19 exposure.
   - Remote technology and short visits that include social distancing/face coverings/disinfection should initially be conducted to allow the youth and caregiver (or congregate care provider) to get to know each other and develop rapport.
   - The team should consider planning extended visitation to minimize the youth moving back and forth between the current residential /group home program and the discharge living arrangement. The timeframe for extended visits may range from 3 to 30 days. In some situations, the planning team may determine youth should be discharged to the discharge living arrangement at the end of the extended visitation period to minimize health risks.
   - All decision making for transitional visitation should be consistent with existing court mandates regarding visitation. When the level of supervision for visitation is at the discretion of the legal case worker, the team should conduct ongoing safety and risk assessment activities to ensure the level of supervision required during visits progresses through the stages (i.e., supervised, unsupervised, overnight, extended) as expeditiously as possible. The planning team should consider including unannounced virtual check-in meetings and supports provided by the team members in the visitation plan when moving to unsupervised, overnight or extended visitation.

3) The planning team should assess risks to safe visitation within the environment of both the residential/group home and targeted discharge living arrangement.
   - Risks within the youth's current residential/group environment include a COVID-19 outbreak within the last 28 days. The team should consider the number of youth and staff with positive test results, the timeframe since a youth or staff had a positive test result, and the infection control and transmission-based procedures implemented by the residential/group home program. When there is not a current outbreak, additional risks to safe visitation include reports by youth or staff of close contacts with COVID-19 positive persons and youth or staff under quarantine.
   - When the targeted discharge living arrangement is home-based, risks to safe visitation include whether a household member tested positive for COVID-19, recent close contact by a household member with someone who is COVID-19 positive, potential exposure risks of household members due to their activities and work within the community, and safety precautions observed by all household members. The team should also determine if older adults and/or people who have severe underlying medical conditions are sharing the home.
   - When the targeted discharge living arrangement is congregate care, risks to be assessed by the team are similar to risks within the youth's current residential or group home environment regarding a recent COVID-19 outbreak and the impact on youth and staff as well as exposure concerns.
   - Strategies to mitigate the identified risks should be incorporated into the visitation planning. Such strategies may include but are not limited to delaying in-person or overnight visits until there are no potential exposure concerns and developing safety rules to which all visit participants agree.

4) Written action plan tasks necessary to complete transitional visits should be communicated to all team members and visit participants. When the CFT leads visitation planning efforts, the DCFS/POS case worker is responsible for communicating action plan tasks. Otherwise, the residential or group home program is responsible for communicating the action plan tasks.

e) Visitation for Medically Complex Youth

Visitation for children with complex medical issues may occur after a CFTM is convened and should include a healthcare provider, medical professional or designee who is knowledgeable about the child's medical condition and can provide a medical opinion as to the safety of the child participating in the family visitation. If no healthcare provider or designee is available to participate in the CFTM after several planned attempts by the caseworker, then a CFS 531 can be completed for DCFS nursing to provide input. Following the medical opinion, if the team decides it is in the best interest of the child to hold **in-person** worker, parent, family and child visitation, the caseworker shall consult with their supervisor, document the critical decision to hold visitation if determined appropriate, and draft a new visiting

plan that outlines guidance or instructions for implementation on an individual case-by-case basis and for each child's unique circumstance. The CFT shall also consider medical issues of family members and caregivers when making decisions about in-person visitation.

Children with Medically Complex diagnosis include **but are not limited to**:

Chronic Lung Disease:
Receiving supplemental oxygen within the last 6 months
Tracheostomy
Ventilator or other respiratory support (e.g. BiPAP)
Cystic fibrosis
Restrictive lung disease
(Exclude asthma unless diagnosed with severe persistent asthma)

Neuromuscular Disease:
Non-ambulatory cerebral palsy
Muscular dystrophy or other neurodegenerative disorders
Dysphasia or aspiration (youth with G tube or GJ tube and unable to take regular oral feedings)

Cardiac Disease:
Congenital heart disease (unless corrected and no longer following with cardiology)
Cardiomyopathy or other acquired heart disease managed by a cardiologist
(Exclude otherwise healthy youth with "heart murmurs")

Immune Suppression:
Cancer or other condition treated with chemotherapy
HIV/AIDS
Immunosuppressive treatment (rheumatologic disorders, chronic systemic steroids)
Transplant recipients or those awaiting transplant
Kidney failure/dialysis

Other:
Youth with other chronic conditions deemed at increased risk of COVID-19 complication by their medical provider

f) DCFS/POS Staff, Vendors, GAL/CASA Visitation

Prior to any in-person visitation with youth in a DCFS Licensed Child Care Institutions, Group Homes and ILO/TLP contact must be made with the facility and visitation must be scheduled with the facility. The facility will be responsible for sharing their On-Site Visitation Plan and provide any educational information that accompanies this plan. The planning for on-site visits with youth should occur during CFTM or other appropriate planning meetings.

The following must be adhered to:

1) All staff must abide by each agency's On-Site Visitation Plan which will include, at a minimum, use of universal masking, social distancing, use of designated visit spaces, time length of visitation, bringing in of food or outside items, number of visitors allowed per youth/visit and change/cancellation procedures.

2) All visitors should supply their own personal face covering and face covering must be worn over mouth and nose during the duration of the visit in the facility and while with the youth. This is to include any visitation occurring in outside spaces. The facility should have masks available should visitors not have their own face covering.

3) All visitors must cooperate with any pre-screening and screening procedures and answer the universal questions consistent with the facilities' On-Site Visitation Plan. No visit should be scheduled if yes is answered to any pre-screening questions outlined in the earlier part of this document.

4) All visitors must cooperate with the agencies' check-in and check-out procedures as outlined in the agencies' On-Site Visitation Plan.

5) All visitors should practice hand hygiene prior to, during and after each visit by washing hands with soap and water for 20 seconds or using hand sanitizer. All visitors should refrain from touching their face during the scheduled visit.

6) No cross-visitation (visiting among the youth's peers within the facility) should occur during the scheduled visit. Visitation should be limited to the participants planned for in the original scheduled visit.

7) All visitors should be alert for symptoms. Watch for fever, cough, shortness of breath, loss of taste or smell or other symptoms of COVID-19. Visitors must report COVID-19 symptoms that developed after the visit (including timeframe) to the agency.

VII. RESOURCES

Direct service staff are urged to follow IDPH and CDC guidelines in all activities. CDC and IDPH guidances are available on these websites:

IDPH COVID-19 Guidance https://dph.illinois.gov/covid19/community-guidance.html

CDC COVID-19 Quarantine and Isolation, https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html

CDC What's New & Updated, https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html

IDPH Long-Term Care Facilities Guidance, https://dph.illinois.gov/covid19/community-guidance/long-term-care.html

Updated Interim Guidance for Nursing Homes and Other Long-Term Care Facilities - Visitation (Summary of changes to guidance since October 20, 2021 release) https://dph.illinois.gov/covid19/community-guidance/communicating-about-covid-19-congregate-settings-long-term-care-facilities.html)

IDPH LTC COVID-19 Visitation Guidance_12.03.21.pdf (illinois.gov)

CDC Guidance for Nursing Homes and Long-Term Care Facilities: Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes | CDC

VIII. QUESTIONS

Staff, supervisors and managers may direct their questions through their chain of supervision. Purchase of Service agencies may contact their APT monitors for additional guidance. All other staff can direct their questions by e-mail through Outlook at DCFS. Policy. Non-Outlook users may send questions to DCFS.Policy@illinois.gov.

IX. FILING INSTRUCTIONS

Remove and recycle Action Transmittals 2021.05 and replace it with this Action Transmittal 2022.01.